New Hampshire Pediatric HIV/AIDS Case Report Form (For patients < 13 years of age)

Mail completed form to: NH DHHS Communicable Disease Surveillance Section, Attn: Heather Barto, 29 Hazen Drive, Concord, NH 03301-6504

I. HIV/AIDS SURVEILLANCE PROGRAM USE ONLY

NH State Number	Soundex Code	Report Status	Date Received	OOS State Number
		New Update	_____/_____/_____	

Document Source	New Investigation	Report Medium	Surveillance Method
A_____-_____-_____-_____	Y N U	1 2 3 4 5 6	A F P R U

II. PATIENT IDENTIFIER INFORMATION – *data not transmitted to CDC*

Patient Legal Name: _____ Phone: ( ) _____-_____
last first middle

Current Address:_____

City:_____ County: _____State: _____ Zip: _____

III. FORM INFORMATION

Date form completed:____/____/_____ Person completing form:_____ Phone: ( ) _____-_____
last first

IV. CURRENT PROVIDER INFORMATION

Physician:_____ Facility Name:_____
last first

City:_____ State:_____ Phone: ( )_____-_____ Med Rec No:_____

V. DEMOGRAPHIC INFORMATION –*complete ALL fields*

Diagnostic Status:
- ☐ Perinatally HIV Exposed
- ☐ Pediatric HIV
- ☐ Pediatric AIDS
- ☐ Pediatric Seroreverter

Sex:
- ☐ Male
- ☐ Female

Date of Birth: ____/____/_____

Country of Birth:
☐ US ☐ US Depend/Posses
☐ Unk ☐ Other_____
_____

Status:
- ☐ Alive
- ☐ Dead

Death Date: ___/_____/_____
State/Terr of Death:
_____

Ethnicity:
Hispanic ☐ Yes ☐ No

Race (check all that apply):
☐ Black/African American ☐ White ☐ Asian
☐ Native American or Alaskan Alaskan Native ☐ Native Hawaiian

Residence at Perinatal Exposure: ☐ Same as Current Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

Residence at HIV Diagnosis: ☐ Same as Current Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

Residence at AIDS Diagnosis: ☐ Same as Current Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

Residence at Pediatric Seroconversion: ☐ Same as Current Street Address:_____
City:_____ County: _____ State/Country: _____ Zip: _____

VI. FACILITY OF DIAGNOSIS Date of Initial Evaluation for HIV: ____/____/_____ Date of Last Medical Exam: ____/____/_____

Facility of Perinatal Exposure: ☐Same as Current _____ Physician: _____
last first
Address: _____City: _____ State/Country: _____ Zip: _____
Facility Type: ☐ Private Physician ☐ Emergency Room ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other:_____

Facility of HIV Diagnosis: ☐Same as Current _____ Physician: _____
last first
Address: _____City: _____ State/Country: _____ Zip: _____
Facility Type: ☐ Private Physician ☐ Emergency Room ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other:_____

Facility of AIDS Diagnosis: ☐ Same as Current _____ Physician: _____
last first
Address: _____City: _____ State/Country: _____ Zip: _____
Facility Type: ☐ Private Physician ☐ Emergency Room ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other:_____

Mother's Demographics:	**Mother's Country of Birth:**	**HIV/AIDS SURVEILLANCE PROGRAM USE ONLY**
Mother's Name: _____ (last / first / middle)	☐ US State: _____	Mother's Soundex
Mother's Date of Birth: ____/____/_____	☐ US Depend/Posses	Mother's State Number
	☐ Other: _____	

Child's biological mother's HIV infection status (check one):

☐ Refused HIV testing ☐ Known *UNinfected* after birth ☐ Unknown
☐ Known HIV positive before pregnancy ☐ Known HIV positive at time of delivery ☐ Known HIV positive sometime after birth
☐ Known HIV positive during pregnancy ☐ Known HIV positive sometime before birth ☐ HIV positive with time unknown

Date of mother's first positive HIV confirmatory test ____/____/_____

Mother was counseled about HIV testing during this pregnancy, labor or delivery? ☐ Yes ☐ No ☐ Unknown

Before their first positive HIV test/AIDS diagnosis this child's mother had:	**Y**	**N**	**U**	**Before their first positive HIV test/AIDS diagnosis this child had:**	**Y**	**N**	**U**
Perinatally acquired HIV infection				Injected nonprescription drugs			
Injected nonprescription drugs				Received clotting factor for hemophilia/coagulation disorder			
HETEROSEXUAL contact with the following:				Received transfusion of blood/blood components (other than clotting factor)			
- Injecting drug user (IDU)				Received transplant of tissue/organs			
- Bisexual male				Sexual contact with a male			
- Male with hemophilia/coagulation disorder				Sexual contact with a female			
- Transfusion recipient with documented HIV infection				Other documented risk			
- Transplant recipient with documented HIV infection				No identified risk factor (NIR)			
- Male with AIDS or documented HIV infection, risk not specified							
- Received transfusion of blood/blood components (other than clotting factor)							
Received transplant of tissue/organs or artificial insemination							

VIII. DOCUMENTED LABORATORY DATA – please record EARLIEST and MOST RECENT tests

HIV TESTS:

	Pos	Neg	Indet	Mo	Day	Yr
HIV DNA PCR						
HIV DNA PCR						
HIV DNA PCR						
HIV 1 EIA						
HIV 1 EIA						
HIV 1/HIV 2 EIA						
HIV 1/HIV 2 EIA						
HIV1 Western Blot						
HIV1 Western Blot						
HIV2 Western Blot						
HIV2 Western Blot						
Other HIV Antibody Test (Specify)_____						
Other HIV Antibody Test (Specify)_____						

VIRAL LOAD TESTS:

Test Type:		COPIES/ML:	Mo	Day	Yr
00 NASBA *03 RT-PCR (stand)* *04 RT-PCR(ultrasen)* *05 bDNA - version 2* *06 bDNA - version 3*					

IMMUNOLOGIC LAB TESTS:

	Mo	Day	Yr
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			
CD4 Count: _____ cells/ul (_____%)			

If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? ☐ Yes ☐ No ☐ Unknown

PHYSICIAN DIAGNOSIS:

If HIV lab tests were not documented, is patient confirmed by a physician to be:

HIV infected Date: ____/____/_____

Not HIV infected Date: ____/____/_____

IX. AIDS INDICATOR DISEASES

Disease:	Initial Dx Date Mo/Day/Yr	Presumptive	Definitive
Bacterial infection, multiple or recurrent (including salmonella septicemia)		☐	☐
Candidiasis, bronchi, trachea, or lungs		☐	☐
Candidiasis, esophageal		☐	☐
Coccidioidomycosis, disseminated or extrapulmonary		☐	☐
Cryptococcosis, extrapulmonary		☐	☐
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		☐	☐
Cytomegalovirus disease (other than liver, spleen, or nodes)		☐	☐
Cytomegalovirus retinitis (with loss of vision)		☐	☐
HIV encephalopathy		☐	☐
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis		☐	☐
Histoplasmosis, disseminated or extrapulmonary		☐	☐
Isosporiasis, chronic intestinal (>1 mo. duration)		☐	☐

Disease:	Initial Dx Date Mo/Day/Yr	Presumptive	Definitive
Kaposi's sarcoma		☐	☐
Lymphoid interstitial pneumonia and/or pulmonary lymphoid		☐	☐
Lymphoma, Burkitt's (or equivalent term)			☐
Lymphoma, immunoblastic (or equivalent term)			☐
Lymphoma, primary in brain			☐
Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		☐	☐
M. tuberculosis, disseminated or extrapulmonary		☐	☐
Mycobacterium of other or unidentified species, disseminated or extrapulmonary		☐	☐
Pneumocystis carinii pneumonia		☐	☐
Progressive multifocal leukoencephalopathy			☐
Toxoplasmosis of brain, onset at >1 mo. of age		☐	☐
Wasting syndrome due to HIV			☐

X. BIRTH HISTORY

Birth history was available for this child: ☐ Yes ☐ No ☐ Unknown *If "No" or "Unknown", proceed to Section XI.*

Birth Hospital:

Name: _____ City: _____ State: _____ Country: _____

Residence at Birth: ☐ Same as Current Address: _____

City: _____ County: _____ State: _____ Country: _____ Zip Code: _____

Birth Weight:
(lbs/oz and/or grams)

_____*lbs.* _____*oz.*

_____*grams*

Birth:

Type: ☐ Single ☐ Twin (A or B) ☐ >2 ☐ Unknown

Mode of Delivery: ☐ Vaginal ☐ Elective Caesarean ☐ Unknown ☐ Non-Elective Caesarean ☐ Caesarean, Unknown Type

Length of Membrane Rupture: _____

Birth Defects: ☐ Yes ☐ No ☐ Unknown

Specify Type(s): _____ Code: _____

Neonatal Status:

☐ Full Term (≥37wks)
☐ Premature (<36 wks)
☐ Unknown

Weeks: _____
99=Unknown, 00=None

Prenatal Care:

Month of pregnancy prenatal care began: _____
99=Unknown, 00=None

Total # of prenatal visits: _____
99=Unknown, 00=None

EDC: _____

Mother's Doctors:

OB: _____
last first

ID: _____
last first

Anti-retroviral (ART) Drug History:

- Did mother receive zidovudine (ZDV, AZT) during pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, starting in what week of pregnancy? _____ *99=Unknown, 00=None*
- Did mother receive ZDV or AZT during labor/delivery? ☐ Yes ☐ No ☐ Unk ☐ Refused
- Did mother receive ZDV or AZT prior to this pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused
- Did mother receive any other ART during pregnancy? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, specify: _____ _____ _____ _____
- Did mother receive any other ART during labor/delivery? ☐ Yes ☐ No ☐ Unk ☐ Refused
  If yes, specify: _____ _____ _____ _____

XI. TREATMENT/SERVICES REFERRALS

This child has received or is receiving:

- Neonatal zidovudine (ZDV,AZT) for HIV prevention: ☐ Yes ☐ No ☐ Unknown Date started: ___/___/____ Time started: _____
- Other neonatal ART medication for HIV prevention: ☐ Yes ☐ No ☐ Unknown Date started: ___/___/____
  If yes, specify: _____
- ART for HIV treatment: ☐ Yes ☐ No ☐ Unknown Date started: ___/___/____
- PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown Date started: ___/___/____

Was child breastfed? ☐ Yes ☐ No ☐ Unknown

Is this child enrolled in a clinic/clinical trial? ☐ Yes ☐ No ☐ Unknown If yes, name: _____

This child's primary caretaker is:

- ☐ Biological parent(s)
- ☐ Other relative
- ☐ Foster/Adoptive parent, relative
- ☐ Foster/Adoptive parent, unrelated
- ☐ Social service agency
- ☐ Other Name: _____
- ☐ Unknown

This child's medical treatment is primarily reimbursed by:

Perinatal Exposure	HIV	AIDS	
☐	☐	☐	Medicaid/Medicare #_____
☐	☐	☐	Private insurance
☐	☐	☐	No coverage
☐	☐	☐	Other public funding
☐	☐	☐	Clinic trial/program
☐	☐	☐	Unknown

This child's siblings:

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last first middle

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last first middle

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last first middle

_____ ☐ M ☐ F Date of Birth: ___/___/____ Birth Hospital: _____
last first middle

XIII. COMMENTS

For questions about reporting call 603-271-3932